Advance Directives - the Ethical Implications

A Response - Iain Macritchie

My two children are young enough for me to be able to remember, quite vividly, the events surrounding each of their births. On each occasion, my wife and I were approached by our community midwife and asked to think about a "birth plan." For the first birth, we had everything carefully planned in advance. The birth was to take place with minimal medical intervention and in the Midwives' Unit, as opposed to the Labour Suite. Very early in labour it became abundantly clear that we were departing from any plan we might have had. Some twenty-seven hours later, our daughter arrived in the Labour Suite, with four doctors and four midwives in attendance. Just over two years later, our son was born in the Midwives' Unit with one midwife present and no birth plan! From a very early stage in both labours, we found ourselves totally dependant on the professional care and advice of the hospital staff, regardless of any plan we may have been encouraged to think of previously. This is exactly what Kenneth Boyd concludes regarding advance directives or living wills, and given my own experiences from the other end of life, I can only endorse this conclusion.

I am most grateful to Kenneth Boyd for such a fine and thought-provoking article. Boyd takes us with clarity and insight through a considerable number of complicated issues, and helps us to appreciate the moral, ethical and religious maze of advance directives in a most lucid presentation. As with all good, stimulating articles, I am left now with a number of questions. It is clear from the outset that the question of `the good death' is as live an issue today as it was in medieval times. The definition of the good death shifts from the medieval notion of death on Crusade and death in a state of grace, or shriven, to the Victorian notion of the death bed scene, with ample opportunity for farewell to family and friends, and now, to the present day good death of consumerism; death with autonomy. It is certainly not hard to envisage a time when the good death will become an article in the charter of human rights. The very term `good death' is value-laden, and might seem to predispose any argument in favour of the teleological line of reasoning, rather than the deontological. In the past, the Christian tradition has been criticised for concentrating too much on the deontological issues of right and wrong, although, given that the concept of a good death has been around for such a long time within the Christian tradition, one wonders whether post-Enlightenment thinking has coloured our view of the Church's praxis in earlier times. Certainly, the question of the good death has been around long enough for both teleological and deontological issues (even when not specifically identified in such terms) to have become familiar elements of the argument. What Ricoeur has done is to examine thoroughly the teleological issue in relation to the deontological one, in order to create a workable synthesis of both these approaches. This synthesis involves, as Boyd comments, an acknowledgement of the teleological issues of good and bad as being the most basic level of ethical thinking, deontological thought then consolidates rules which distinguish between right action and wrong action. When deontological thinking gets stuck and proves unhelpful, there follows a return to the more basic level of ethical thinking, the teleological, which, motivated by solicitude (compassion) provides practical wisdom to betray the deontological rule to the least extent possible.

At first reading, such a synthesis seems to be eminently sensible, and has much to recommend it. Ethical thinking is based on a concept of the good in life and how to achieve it, as well as the bad in life and how to avoid it. Every effort is being made to acknowledge and adhere to the accepted rules that every reasonable person ought to agree to obey. These rules are only betrayed to the least extent possible and by recourse to our original concepts of good and bad. No future rule is to be made by the breaking of the original rule. Finally, the motivating factor for the breaking of the rule is practical wisdom born of solicitude, i.e. feelings that are revealed in the self by the other's suffering. While this describes with accuracy what actually takes place in practice in the area of advance directives, a number of difficulties can still be identified. These are all acknowledged to some extent in the article, but I simply highlight them for further consideration. First of all, there is the inescapability of value judgements and subjectivity we might seek to avoid. As soon as terms such as "good and bad," "appropriate and inappropriate" and "right and wrong" are introduced, there is a real difficulty in gaining the very consensus of reason required to ratify the choice made. For example, Boyd states that advance refusals amount to no more than requesting that the person concerned should not be kept alive using extraordinary or disproportionate means. What is our standard of ordinariness to be here? And in disproportion to what? While we can all imagine clear cases where someone should not be kept alive, increasingly, the world of healthcare is not made up of these

cases, but of more borderline cases, and where that which might be extraordinary and disproportionate today is commonplace tomorrow. There is no consensus of reason possible here, but once more we are reliant on the depth of compassion exercised by our carers.

Another issue is that of precedent. It is effectively impossible not to make a rule out of an exception. Once a case has been made for the avoiding of one particular rule, a similar case is made for avoiding it again, often, as Boyd points out, in less justifiable cases. Moreover, if the making of an exception is motivated by solicitude, or the feelings that are revealed in the self by the other's suffering, then, once again we find ourselves relying upon our carers' sense of compassion. So, is the real issue here not one of trust? It seems that, in the age of the individual, complete with consumer choice, autonomy, and personal freedom, then professional competency is being challenged more and more. Where once it was more or less taken for granted that a professionally trained person knew what s/he was doing, and the individuals professional training was accepted as qualification to earn our trust, in today's world things are markedly different, and the lay individual, as customer or client, has at least as much say in things as the professional. While this undoubtedly has a number of benefits, the new situation brings with it a new set of responsibilities, not least how to exercise professional care while constantly involving the client in the decisions which are being taken in the client's interest. Ironically, this is a situation which the clergy have had to accept for longer than our friends in the medical profession, but no profession today finds itself above criticism, nor is any professional given the instant, unquestioned trust accorded in previous generations. Such trust is now earned, not taken for granted. A recent article in BMJ, highlighting American guidelines on end of life care, pointed out that a major factor preventing the development of policy was the growing distrust on the part of patients and their relatives, particularly when cost control was perceived to be a factor of care management.

However, now and again some of the assumptions which are made in this age of individualism and consumerism need to be challenged. This is true in the area of healthcare in general, and advance directives in particular. In such areas of life we are, in fact, least autonomous, most vulnerable, and most dependant on other people. While this then heightens our craving for autonomy, the fact remains that there are some situations in life where we are not in control, where we are not autonomous, and where we are highly dependant on the compassion and care of our fellow human beings. This is the very point with which Boyd concludes his article.

The challenge which Boyd extends to the Church and to Chaplaincy at this point, is to foster, nourish and grow that sense of belonging to one another, that sense of our interconnectedness, on which compassion or solicitude depends. This is the real issue at the heart of any discussion on advance directives. The question is whether we, as Chaplains, can make our own invaluable contribution to the darning of the holes in the fabric of our society, and create a strong and supportive new material. Like any needlework, this is a painstaking activity, and is not done in a hurry. It involves working with the individual threads of our connectedness to ensure that no one falls through the gaps.

How then, as Chaplains do we, in our own very specific areas of work, encourage and maintain this relatedness on which solicitude or compassion depend? This is a life or death question for us. As a potential client, I want to believe that no clinician deliberately sets out to "prolong suffering," with or without the use of modern medical technology, and, therefore, no advance directive should be necessary to "discourage clinicians" from doing this. On the other hand, I also want to believe that every effort is being made to maintain as high a quality of life as is possible for any individual at any given time, and that no act, even of nonmaleficence, would end life prematurely.

My concern is that, as the sheer numbers of elderly people increases, and as precedence pushes more and more on the boundaries of acceptability, solicitude will decrease proportionately. Then, on the one hand, people may be kept alive beyond propriety (and the difficulty of defining such a parameter is already acknowledged) or, of perhaps greater concern, people may not be kept alive simply through a deficit of solicitude on the part of their carers.

It seems to me that the crucial role of Chaplaincy here is to encourage models of community and interdependence in a fragmented and individualistic world, so that the worth and dignity of the person within that community is both acknowledged and maintained. If it is indeed through other persons that we discover our own personhood, then this is the challenge to Chaplaincy, to create that sense of connectedness, with ourselves, with other people, with the world, and with our God, that enables us to discover and affirm solicitude.

References

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